Supreme Court, U. S.
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# In the Supreme Court of the United States

OCTOBER TERM, 1977

**No. 77-1621**

BYRON TIMOTHY LIGGETT,
*Appellant,*

vs.

STATE OF KANSAS, EX REL., CURT T. SCHNEIDER, ATTORNEY GENERAL, KANSAS HOSPITAL ASSOCIATION, THE KANSAS MEDICAL SOCIETY, THE KANSAS HEALTH CARE PROVIDER INSURANCE AVAILABILITY PLAN,
*Appellees.*

ON APPEAL FROM THE SUPREME COURT OF KANSAS

## JOINT MOTION TO DISMISS OR AFFIRM

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ON APPEAL FROM THE SUPREME COURT OF KANSAS

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## JOINT MOTION TO DISMISS OR AFFIRM

The appellees move, pursuant to S.Ct.R. 16, to dismiss this appeal or affirm the decree on the ground that: (1) the Kansas Supreme Court specifically found, as a factual matter, that the statute in question was reasonably necessary to the promotion of the public health and welfare; (2) this court has held in a long line of cases that such a finding is sufficient to uphold a statute as against a due process attack; and (3) the issue presented is therefore not a substantial federal question deserving of briefing or argument.

## I.

## STATEMENT

### A.

### Statutes

The appellant seeks to challenge a compulsory insurance requirement imposed upon him by the Kansas Health Care Provider Insurance Availability Act [Kan. Stat. Ann. 40-3401 to 3419 (Supp. 1977)]. The Act was passed by the 1976 Kansas legislature, along with 11 other bills, as a response to what was perceived to be a severe problem caused by increasing premiums for and decreasing availability of professional liability insurance for health care professionals. *See generally* Note, *Recent Legislation*: The *Kansas Approach to Medical Malpractice*, 16 Washburn L.J. 395 (1977). The primary feature of the act is a requirement that all "health care providers" carry, as a condition of practicing within the state, basic professional liability coverage in the amount of $100,000 per occurrence with a $300,000 annual aggregate for all claims made during the policy period. Kan. Stat. Ann. 40-3402(a) (Supp. 1977). In addition, all health care providers are required to pay a surcharge on all policies, which in turn is paid into a state-administered fund that provides excess coverage for any liability beyond the basic $100,000/$300,000 limit. Kan. Stat. Ann. 40-3404(a) (Supp. 1977). The term "health care provider" is defined as a person licensed or who holds a temporary or fellowship permit under the Kansas Healing Arts Act, a medical care facility, a health maintenance organization, an optometrist, a podiatrist, a pharmacist, a nurse anesthetist, or a professional corporation made up of individuals engaged in such professions, a dentist licensed to administer anesthetics, a physical therapist,



or a mental health center or clinic. Kan. Stat. Ann. 40-3401(f) (Supp. 1977).

### B.

### Proceedings Below

The appellant in this case, a physician, refused to comply with the compulsory insurance requirement and, on August 2, 1977, was enjoined by the District Court of Barton County, Kansas from practicing medicine until such time as he did so. By entering such an order, the court rejected the appellant's contention that the requirement violated the due process and equal protection clauses of the fourteenth amendment.

Although the trial court recognized the constitutional issues alleged to exist, it viewed the case as one primarily hinging upon its peculiar facts. The record before it consisted of over 1,000 pages of legislative testimony and other material replete with references to the twin problems of increasing costs and decreasing availability of malpractice insurance. The record reflected significant concern as to the possibility that the problems might drive established practitioners from the state and discourage new ones from establishing themselves, thereby causing a general decrease in the quality of health care available to the Kansas public. Kansas is, of course, a rural state with an already-severe health care problem caused by a shortage of trained personnel. The trial court concluded, in light of the impressive testimony outlining the problem and proposing compulsory insurance as the most likely solution, that without question the legislature could have reasonably decided that compulsory insurance was necessary. In support of its conclusion, the trial court entered, as an appendix to its Journal Entry of Judgment, numerous findings of fact outlining in detail the lengthy testi-

mony heard by the legislature. The appellant has neglected to include that appendix in his jurisdictional statement but it may be found herein as Appendix A.

Upon appeal to the Supreme Court of Kansas, the decision of the trial court was affirmed. *State ex rel. Schneider* v. *Liggett,* 223 Kan. 610, 576 P.2d 221 (1978). The Kansas Supreme Court rejected the appellant's equal protection claim, a point that is not pursued here. It also held that the mandatory insurance provisions do not violate due process, finding that "[m]andatory malpractice insurance bears a rational relationship to the health and welfare of the citizens of this state by not only providing protection to patients who may be injured as a result of medical malpractice, but by assuring that there continues to exist in the state an adequate supply of health care providers." *Id.* 223 Kan. at 616, 576 P.2d at 227.

## II.

## ARGUMENT

Ever since the demise of substantive due process exemplified by *Lochner* v. *New York,* 198 U.S. 45, 25 S.Ct. 539, 49 L.Ed. 937 (1905), this court has generally refused to inject itself into a legislative debate as to the wisdom or utility of a particular legislative policy. *See Moore* v. *City of East Cleveland, Ohio,* 431 U.S. 494, 97 S.Ct. 1932, 52 L.Ed.2d 531 (1977); *Ferguson* v. *Skrupa,* 372 U.S. 726, 83 S.Ct. 1028, 10 L.Ed.2d 93 (1963); *Bartkus* v. *Illinois,* 359 U.S. 121, 79 S.Ct. 676, 3 L.Ed.2d 684 (1959); *Nebbia* v. *New York,* 291 U.S. 502, 54 S.Ct. 505, 78 L.Ed. 940 (1934). As this court has expressly stated, it does not "sit as a superlegislature to weigh the wisdom of legislation nor to decide whether the policy which it expresses offends



the public welfare." *Day-Brite Lighting, Inc.* v. *Missouri,* 342 U.S. 421, 423, 72 S.Ct. 405, 407, 96 L.Ed. 469, 472 (1952). State legislatures thus have "constitutional authority to experiment with new techniques" entitling them to their "own standard of the public welfare" and this court will "leave debatable issues as respects business, economics, and social affairs to legislative decision." *Id.,* 342 U.S. at 423, 425, 72 S.Ct. at 407, 408, 96 L.Ed. at 472, 473. As was said in *Williamson* v. *Lee Optical Co.,* 348 U.S. 483, 75 S.Ct. 461, 99 L.Ed. 563 (1955), a case involving state regulation of ophthalmologists, optometrists and opticians:

> It is enough that there is an evil at hand for correction, and that it might be thought that the particular legislative measure was a rational way to correct it.
>
> The day is gone when this Court uses the Due Process Clause of the Fourteenth Amendment to strike down state laws, regulatory of business and industrial conditions, because they may be unwise, improvident, or out of harmony with a particular school of thought.

*Id.* 348 U.S. at 488, 75 S.Ct. at 464, 99 L.Ed. at 572.

The appellant nonetheless suggests that those established principles are somehow inapplicable to him. He contends that in the area of occupational licensing this court has forever limited the parameters of the police power to regulation reasonably related to fitness and competency. To the contrary, however, this court has expressly stated that the boundaries of the police power are always flexible, never rigid. *Berman* v. *Parker,* 348 U.S. 26, 75 S.Ct. 98, 99 L.Ed. 27 (1954); *Noble State Bank* v. *Haskell,* 219 U.S. 104, 31 S.Ct. 186, 55 L.Ed. 112 (1911). This court has in fact repeatedly recognized that the states

possess especially broad power in the area of occupational licensing because it is so peculiarly affected by the public interest. *North Dakota State Board of Pharmacy* v. *Snyder's Drug Stores, Inc.*, 414 U.S. 156, 94 S.Ct. 407, 38 L.Ed.2d 379 (1973); *Williamson* v. *Lee Optical Co.*, 348 U.S. 483, 75 S.Ct. 461, 99 L.Ed. 563 (1955); *In Re Summers*, 325 U.S. 561, 65 S.Ct. 1307, 89 L.Ed. 1975 (1945). *See also Buschbacher* v. *Supreme Court of Ohio*, No. C-2-75-743 (S.D. Ohio, filed Oct. 13, 1976), *affirmed Mem. sub. nom., Cuyahoga County Bar Association* v. *Supreme Court of Ohio*, 430 U.S. 901, 97 S.Ct. 1167, 51 L.Ed.2d 577 (1977).

For example, in *Williamson* v. *Lee Optical Co.*, the law in question prohibited opticians from fitting or duplicating lenses without a prescription. It also prohibited advertising by all eye care professionals and barred retail stores from furnishing space for eye examinations. The requirements clearly bore no particular relationship to fitness or competency. In fact, the evidence tended to show that the public benefit was at best remote and, in all likelihood, imaginary. Nonetheless, the law was upheld:

> The . . . law may exact a needless, wasteful requirement in many cases. But it is for the legislature, not the courts, to balance the advantages and disadvantages of the new requirement. . . . [T]he law need not be in every respect logically consistent with its aims to be constitutional. It is enough that there is an evil at hand for correction, and that it might be thought that the particular legislative measure was a rational way to correct it.

*Id.* 348 U.S. at 487-88, 75 S.Ct. at 464, 99 L.Ed. at 571-72.

Moreover, even during the *Lochner* era of due process this court recognized that the state could, pursuant to its police power, require members of a given profession



to maintain a bond. It upheld a Kansas law that required livestock commission merchants to provide a bond as a prerequisite to doing business. *Payne* v. *State ex rel. Brewster*, 248 U.S. 112, 39 S.Ct. 32, 63 L.Ed. 153 (1918), *affirming State ex rel. Brewster* v. *Mohler*, 98 Kan. 465, 158 P. 408 (1916). Similarly, mandatory insurance for public carriers has withstood the same attack made here. *Continental Baking Co.* v. *Woodring*, 286 U.S. 352, 52 S.Ct. 595, 76 L.Ed. 1155 (1932). Health care is certainly as affected with the public interest as are public carriers. *See Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 354, 95 S.Ct. 449, 455, 42 L.Ed.2d 477, 485 (1974); *Semler* v. *Oregon State Board of Dental Examiners*, 294 U.S. 608, 612, 55 S.Ct. 570, 572, 79 L.Ed. 1086, 1090 (1935); *Nebbia* v. *New York*, 291 U.S. 502, 54 S.Ct. 505, 78 L.Ed. 940 (1934). Finally, a form of insurance that affects every citizen has been upheld by this court—Social Security. *Helvering* v. *Davis*, 301 U.S. 619, 57 S.Ct. 904, 81 L.Ed. 1307 (1937).

In consequence, several state courts have upheld mandatory insurance or bond requirements. *See City of Tucson* v. *Stewart*, 45 Ariz. 36, 40 P.2d 72 (1935). Compulsory insurance is therefore a fact of life for many professions and occupations. The Kansas Supreme Court identified seven different vocations required by Kansas law to maintain liability insurance. *State ex rel. Schneider* v. *Liggett*, 223 Kan. 610, 615, 576 P.2d 221, 226 (1978). The Idaho Supreme Court identified nine in an opinion presenting the identical question involved here. *Jones* v. *State Board of Medicine*, 97 Idaho 859, 555 P.2d 399 (1976), *cert. denied*, 431 U.S. 914, 97 S.Ct. 173, 53 L.Ed.2d 223 (1977). Thus, the issue has long been settled and no longer presents a substantial federal question. This court obviously recognized that just last term when it denied certiorari in *Jones* v. *State Board of Medicine*.

The two cases relied upon by the appellant do not stand for a contrary result. The first, *Dent* v. *West Virginia*, 129 U.S. 114, 9 S.Ct. 231, 32 L.Ed. 623 (1889), was an early occupational licensing case in which the court recognized the breadth of the police power and that under it the states were "authorized" to impose training and skill requirements on the professions. *Id.*, 129 U.S. at 122, 9 S.Ct. at 223, 32 L.Ed. at 626. The case does not stand for the proposition asserted by the appellant and most certainly does not establish a rule forever cast in stone:

> In this country, the requirement [of due process] is intended to have a similar effect against legislative power, that is, to secure the citizen against any arbitrary deprivation of his rights, whether relating to his life, his liberty, or his property. *Legislation must necessarily vary with the different objects upon which it is designed to operate.* It is sufficient, for the purposes of this case, to say that legislation is not open to a charge of depriving one of his rights without due process of law, if it be general in its operation upon the subjects to which it relates, and is enforceable in the usual mode established in the administration of government with respect to kindred matters, that is, by process or proceedings adapted to the nature of the case. The great purpose of the requirement is to exclude everything that is arbitrary and capricious in legislation affecting the rights of the citizen.

*Id.*, 129 U.S. at 124, 9 S.Ct. at 234, 32 L.Ed. at 626 (emphasis added). In this case of course the object was not to insure competent practitioners but, rather was to reduce the cost and increase the availability of malpractice insurance. Such difference in purpose may obviously lead to a difference in method.



The second case relied upon by the appellant, *Schware* v. *Board of Bar Examiners*, 353 U.S. 232, 77 S.Ct. 752, 1 L.Ed.2d 796 (1957), is even further from the mark. The case stands for two propositions. The first is that the old right-privilege distinction exemplified by *Barsky* v. *Board of Regents*, 347 U.S. 442, 74 S.Ct. 650, 98 L.Ed. 829 (1954), is no longer valid. 353 U.S. at 239 n.5, 77 S.Ct. at 756, 1 L.Ed.2d at 801. The second is that the state may not penalize the exercise of first amendment rights by a licensee or an applicant for a license by denying or revoking an occupational license on that basis; *Schware* centered upon a refusal to permit a law school graduate to take the bar examination because of previous political associations. Although the court used broad language that has been seized upon by the appellant, the primary authorities cited leave no doubt that the court regarded the case as one involving first amendment rights. In both of the cases cited [*Slochower* v. *Board of Education*, 350 U.S. 551, 76 S.Ct. 637, 100 L.Ed. 692 (1956) and *Wieman* v. *Updegraff*, 344 U.S. 183, 73 S.Ct. 215, 97 L.Ed. 216 (1952)], the court utilized the due process clause to protect first amendment freedoms. The point was more clearly made in *Schware's* compansion case, *Konigsburg* v. *State Bar*, 353 U.S. 252, 77 S.Ct. 722, 1 L.Ed.2d 810 (1957), in which the court held that the power of a state to select its bar could not be exercised in an "arbitrary or discriminatory manner nor in such way as to impinge on the freedom of political expression or association." 353 U.S. at 273, 77 S.Ct. at 733, 1 L.Ed.2d at 825. In addition, subsequent cases have interpreted *Schware* as one involving the first amendment. *See Baird* v. *State Bar of Arizona*, 401 U.S. 1, 91 S.Ct. 702, 27 L.Ed.2d 639 (1971); *Keyishian* v. *Board of Regents*, 385 U.S. 589, 87 S.Ct. 675, 17 L.Ed.2d 69 (1967). This is patently not a first amendment case.

Finally, although it is not binding on this court, brief mention should be made of *McGuffey* v. *Hall*, 557 S.W.2d 401 (Ky. 1977), in which the Kentucky Supreme Court concluded that compulsory malpractice insurance was unconstitutional. The case is hardly persuasive because the Kentucky court's analysis was the exact opposite of that utilized by this court. It placed the burden on the state to justify the legislation and then found that "the provision for compulsory malpractice insurance has not been shown to be justified as an exercise of the police power." 557 S.W.2d at 414. Moreover, the decision rested on the Kentucky Constitution: "We express no opinion with respect to the due process provision of the federal Constitution, which in latter times has become something of a moving target, defying captivity." 557 S.W.2d at 414. The decision was also made in a vacuum, without reference to any legislative facts justifying the legislation:

> We have held the compulsory insurance requirement invalid because there is neither a showing nor anything else of which we may take judicial notice to indicate how it might tend to alleviate the problem of scarcity and high cost of medical malpractice insurance. *It is entirely possible that this deficiency can be remedied.*

557 S.W.2d at 416 (emphasis added). The findings of fact entered in this case conclusively remedy any "deficiency," if in fact one exists.

## III.

## CONCLUSION

In a nutshell, therefore, this court has for many years upheld broad utilization of the police power, requiring



only that legislation have some connection with the problem at hand. The findings entered in this case clearly show the existence of such a connection. The appellees therefore move the court to dismiss this appeal or, in the alternative, to affirm the judgment entered in the matter by the Supreme Court of Kansas on the ground that the issue involved has long been decided and no longer presents a substantial federal question.

Respectfully submitted,

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## APPENDIX "A"

**Appendix to Barton County District Court**
**Journal Entry of Judgment**

(Filed August 2, 1977)

### APPENDIX I

*Legislative Facts*

1. The interim special legislative committee on medical malpractice met seven times. At each meeting, a number of representatives from legal, medical, and insurance groups were present. (Minutes of special committee on medical malpractice for June 24/25, 1975, July 22/23, 1975, August 27/28, 1975, September 23/24, 1975, October 14, 1975, October 28, 1975, November 13/14, 1975.)

2. The interim committee at its first meeting was told that the medical liability insurance problem was nationwide although the problem had perhaps not reached crisis proportions in Kansas. (Interim committee minutes, June 24/25, 1975, p. 2.)

3. The committee heard a synopsis of the views of medical providers, the insurance industry, the legal profession, and consumer groups. (Minutes, June 24/25, 1975, Attachment A.)

4. The committee was also told that the Kansas Medical Society had reported in February, 1975, that premiums had increased 50 to 150 percent during the past three years with some increases going as high as 300 percent. It was also told that a number of insurance companies writing coverage in the state would not accept new physicians for coverage, that the physicians who had had claims

filed against them had a chance at being canceled, and that a number of letters had been received from practitioners in the state who could not find an insurer. Finally, the committee heard that some sources had stated that the ratio of malpractice claims per doctor in the state of Kansas went from 1 in 33 in 1969 to 1 in 18 in 1973. (Minutes, June 24/25, 1975, p. 4, Attachment A.)

5. The committee was told that the Department of Health, Education and Welfare had commissioned a study of the medical malpractice insurance problem, and a copy of a summary of that committee's recommendations was made available to the interim committee members. (Minutes, June 24/25, 1975, Attachment B.)

6. Summaries of legislation proposed in the Congress and either proposed or enacted in various states were also given to committee members. (Minutes, June 24/25, 1975, Attachments G through O.) One of the states mentioned, Wisconsin, had passed a bill permitting its commissioner of insurance to establish a mandatory risk-sharing plan involving compulsory liability insurance for health care providers. (Minutes, June 24/25, 1975, Attachment N.)

7. The interim committee members also received a copy of an article setting forth the insurance industry's view of the problem, a newspaper report taking note of the increasing malpractice insurance problem in a number of states and a summary of the law of damages and of limitations of actions as they relate to medical malpractice. (Minutes, June 24/25, Attachments C through E.)

8. Finally, the committee heard Fletcher Bell, Kansas Commissioner of Insurance, and representatives of Kansas hospitals testify as to their view of the problem. (Minutes, June 24/25, 1975.)



9. Commissioner Bell told the committee that the insurance problem had not yet reached a crisis point in Kansas but that there were "some disturbing indications that this period of relative tranquility is coming to an end." Bell noted that there was already a potentially serious problem in Hutchinson and another in Wichita caused by the withdrawal of Lloyds of London from the medical malpractice insurance market. He noted that "everyone must share in the responsibility and everyone must be willing to contribute and perhaps even sacrifice a portion of the advantages they now have if we are to avoid some of the difficulties experienced in other localities." (Minutes, June 24/25, 1975, Attachment P.)

10. Frank Gentry, of the Kansas Hospital Association, told the committee that the problem in Kansas had become "extremely severe" in the last 18 months, especially with the withdrawal of the Argonaut Insurance Company from Kansas. Mr. Gentry cited as examples of the problem two increases in hospital premiums of 300 percent and one of 400 percent in the year immediately preceding. He also stated that although he had no proof he strongly believed that a national factor was computed into Kansas premiums in a manner that caused Kansas premiums to be higher than its claim experience would otherwise require. (Minutes, June 24/25, 1975, Attachment S.) Mr. Gentry also gave to each interim committee member an American Hospital Association report containing details of the problem on a state-by-state basis. (Minutes, June 24/25, 1975, Attachment T.)

11. Mr. Jerry Jorgensen, administrator of Stormont-Vail Hospital in Topeka, explained his view of the problem and noted that the medical liability portion of his hospital's insurance was on the increase. (Minutes, June 24/25, 1975, pp. 12-13.)

12. Mr. Steve Blaes, an attorney, told the committee that the insurance problem could drive hospital costs upward, cause increasing defensive medicine practices, force many older and part-time physicians into early retirement, cause young physicians to forego private practice entirely, and have an adverse effect on hospital bond offerings. (Minutes, June 24/25, 1975, Attachment U).

13. The interim committee members also received from Commissioner Bell copies of reports on medical malpractice insurance in Kansas prepared by him and dated March 14, 1975, and June 25, 1975. (Minutes, June 24/25, 1975, Attachments Q and R.)

14. In the March 14, 1975, report (Attachment B), Commissioner Bell noted that:

(a) The Kansas public could suffer from lack of adequate numbers of health care providers and from higher health care costs if the malpractice insurance problem were not resolved;

(b) Approximately 15 insurance companies were licensed to write malpractice coverage in Kansas, but the estimated Kansas premium volume represented only .7 percent of the national total of premiums collected;

(c) Of the companies writing insurance coverage in this state, the Medical Protective Company provided 50 percent of the coverage and the St. Paul Insurance Companies 36 percent. Hartford Accident and Indemnity Company wrote 6 percent and other companies 8 percent;

(d) Although the Kansas rate was relatively low, insurance companies were nevertheless reluctant to write coverage for additional health care providers because of the steadily increasing malpractice claim settlement costs and claims frequency potential;



(e) Data compiled by the Insurance Commissioner's office showed the ratio of claims per doctor to have increased from 1 in 33 in 1969 to 1 in 18 in 1973;

(f) The so-called "long tail" of medical malpractice insurance caused by claims incurred but not reported until sometime after the actual injury was causing substantial problems in establishing fair premiums;

(g) The unfavorable loss experience of the insurance companies on a national basis, changes in the public attitude and in legal opinions, and the inflated economy were all three causes of the lack of market stability in Kansas;

(h) Additional or higher rates would not induce availability of insurance;

(i) He had been informed that some individual medical practitioners had ceased to practice in Kansas because adequate insurance coverage was not available.

15. The June 25, 1975, report (Attachment Q) supplemented the March 14 report. In it, Commissioner Bell noted that:

(a) Two companies had requested rate increases of 200 percent or more.

(b) The Liberty Mutual Insurance Company had indicated a desire to withdraw from the state.

(c) New physicians and surgeons were frequently requesting the insurance department's assistance in locating adequate coverage, and without the direct assistance of the department, the necessary insurance coverage was difficult to obtain.

(d) Even the two largest carriers of malpractice insurance in the state did not write enough premium volume to be used as a creditable basis for rate formulation based only on the Kansas experience.

16. At its July meeting, the interim committee was told by Dr. Don George, interim association dean of the Wichita branch of the University of Kansas Medical School, that a group of private practitioners who taught at the Wichita Medical School had encountered substantial difficulty in obtaining coverage for their teaching activities. He noted that the problem was the only one of its kind to date but that if it became the trend it would result in the closing of the Wichita branch of the medical school or in the expenditure of state money to provide full-time faculty. (Interim committee minutes, July 22/23, 1975, p. 3.)

17. Dr. David Robinson, acting executive vice chancellor of the University of Kansas Medical Center, stated that doctors were practicing defensive medicine and were not attempting new techniques because of the insurance problem. He noted that it had been estimated that the insurance problem added 12 to 15 billion dollars per year to the public's medical bills. (Minutes, July 22/23, 1975, p. 5.)

18. The interim committee also heard Roy House, administrator of Wesley Medical Center in Wichita, Kansas, explain that the premium cost for Wesley had gone from $13,000 per year from mid-1958 through mid-1969 to $103,-000 per year from mid-1969 to mid-1973 and then to $158,-000 per year from mid-1973 to mid-1974. Mr. House also noted that Wesley's coverage had been canceled as of January 1, 1975, and that Wesley was able to obtain insurance only at a premium of $652,000 per year, a 300 percent increase that necessitated a $2 increase in the daily service charge. (Minutes, July 22/23, 1975, pp. 9-10). Mr. House told the committee that the malpractice problem was jeopardizing long-term hospital financing, posed a threat to emergency care, jeopardized high-risk services, threatened



medical education in Kansas, and posed problems in the development of out-patient programs. (Minutes, July 22/23, 1975, p. 10.) Mr. House told the committee that if the private sector could not make malpractice insurance available, the state should go into the insurance business because the problem was public in nature. (Minutes, July 22/23, 1975, pp. 11-12.)

19. Mr. Jim Clark, of the Kansas Optometric Association, noted that his group was facing substantial problems in availability of coverage. (Minutes, July 22/23, 1975, p. 15.)

20. Dr. John Travis, president of the Kansas Medical Society, told the committee that the malpractice problem had led to the practice of defensive medicine, had caused a deterioration in the climate between the doctor and the patient that adversely effected the quality of care, and could limit the availability of service. (Minutes, July 22/23, 1975, p. 15.)

21. Dr. Steven Brunner, a young family practitioner who opened his practice in Pittsburg in July, 1975, told the committee of the problems that he had had in obtaining coverage. He noted that the problems he had faced in Kansas had caused him to consider other states and that the insurance problem in Kansas could cause young family doctors to go elsewhere. (Minutes, July 22/23, 1975, pp. 15-16.)

22. Dr. Tony Mahaffee, of Baxter Springs, told the committee that the malpractice problem could cause him to leave Baxter Springs. (Minutes, July 22/23, 1975, p. 16.)

23. Dr. Dan Caliendo, of Wichita Emergency Care, explained the problems that his group had faced in obtaining the necessary coverage. He noted that they had ob-

tained coverage only after the direct intervention of the Insurance Commissioner's office and then at an increase of 2,000 percent. (Minutes, July 22/23, 1975, pp. 16-17.)

24. Dr. John Morgan, of Emporia, told the committee that when his company withdrew from the market, his group received repeated refusals from seven companies and was considering abandoning its practice when a local agent secured a policy for it. (Minutes, July 22/23, 1975, p. 17.)

25. Dr. Jim Leffler, of Wichita, told the committee that the problem was statewide and could be expected to increase in severity. He noted that one ophthalmologist's premium had risen from $1,000 to $9,000. (Minutes, July 22/23, 1975, p. 17.)

26. Dr. Bill VonRuden, of Hutchinson, explained the problems of his group. He noted that one part-time anesthesiologist was quoted a premium of $20,000 which was probably more than she made. He also noted that premiums for his group were $1,900 in 1974 and $41,000 in 1975. (Minutes, July 22/23, 1975, pp. 17-18.)

27. A Kansas Medical Society physician paper was distributed to committee members. The paper noted that health care practices were being adversely affected by the malpractice insurance problem and recommended a number of steps including a state-managed patients' compensation fund. (Minutes, July 22/23, 1975, Attachment K.)

28. The committee also heard extensive testimony from a number of groups during its meeting on August 27 and 28, 1975.

29. Lloyd Hall, executive secretary and general counsel of the Kansas Association of Osteopathic Medicine,



told the committee that the insurance problem was acute for new doctors. He indicated that his association supported the recommendations of the Kansas Medical Society. (Minutes of August 27/28, 1975, p. 2.)

30. Representatives of the podiatrists, chiropractors, and nurses also appeared. (Minutes, August 27/28, 1975, pp. 3-4.)

31. Representatives of the Kansas Bar Association, the Kansas Trial Lawyers Association, and the Kansas Association of Defense Counsel appeared to present position papers. (Minutes, August 27/28, 1975, pp. 5-8.)

32. Mr. Frederick J. Knox, vice president and chief actuary for the St. Paul Fire and Marine Insurance Company, explained the procedures followed by his company in establishing rates. Exhibits submitted by him to the committee members showed that St. Paul would incur a loss for the year 1969, the most recent year in which its complete cost was then known. (Minutes, August 27/28, 1975, p. 8, Attachment K.)

33. Mr. David W. Wilson, assistant vice president of the Medical Protective Company, explained his company's experience and submitted statistics showing that the company projected a loss on every dollar in premiums collected in 1974. (Minutes, August 27/28, 1975, Attachment L.) Mr. Wilson stated that a catastrophic fund to pay large judgments would encourage companies to come back into the malpractice insurance field. (Minutes, August 27/28, 1975, p. 10.)

34. Commissioner Bell once again appeared before the committee and presented a written report supplementing his previous reports. The report contained a number of recommendations that Bell said should be considered as a package. (Minutes, August 27/28, 1975, p. 10.)

35. The report noted that coverage was no longer available for new anesthesiologists and that anesthesiologists in general were facing substantial problems. (Minutes, August 27/28, 1975, Attachment O.)

36. The report also contained a detailed outline of reports of committees made up of insurance, medical, legal, and general public representatives, under the direction of the Commissioner, all of which studied specific aspects of the problem.

37. The report summarized the Kansas situation as follows:

> "Widespread availability in cost problems related to professional liability insurance for Kansas physicians, surgeons and hospitals were first encountered in the fall of 1974 when several of the major professional liability insurers requested significant rate increases. Although the percentage of the requested rate increases did not vary significantly from prior rate proposals (the average annual rate increase for the calendar years 1968 through 1973 is approximately 50 percent per year), the companies proposing these latest increases indicated that approval of the new rates would permit their companies to renew only existing policies; that is, even if the higher rates were approved, no new policies would be written by these companies in the state of Kansas. In order to prevent a major crisis from developing, this Department sought and received informal commitments from the major insurance companies, which have traditionally provided a majority of the Kansas physicians, surgeons and hospitals' professional liability insurance market, to renew all existing policies whenever possible and also provide additional coverage for any new physician or surgeon



> establishing or joining an existing medical practice in the state of Kansas. Furthermore, the assistance and cooperation of other admitted insurance companies were solicited, and informal agreements were made to the effect that all insurance companies would attempt to remain in the Kansas physicians, surgeons and hospitals' professional liability insurance market. Until late June of 1975, these informal commitments appeared to be providing a somewhat stabilized market for the health care providers insured by the admitted (regulated) insurance market. At this time, the first information of an impending withdrawal of the Lloyds of London underwriters, (a non-admitted or unregulated insurance facility) from the United States medical malpractice insurance market became available, and by July 1, 1975, the Lloyds had finally withdrawn from this essential market. As pointed out earlier in this report, this department is not able to provide a detailed evaluation of the impact of Lloyds' withdrawal. Other situations occurring in June, such as the reduction of policy limits by one major insurance company, adversely affected the Kansas malpractice insurance market; and just recently, two insurance companies have notified this department regarding the elimination of new and renewal primary and/or excess coverages for anesthesiologists."

The Commissioner closed the report with the warning that the problems faced in the state with continued availability of insurance "are most serious, and they must be dealt with and resolved as quickly as possible" and that if delays are encountered "the availability and cost problems encountered with medical professional liability insurance will become more serious than ever before." (Minutes, August 22/23, 1975, Attachment O.)

38. The next meeting of the interim committee was September 23/24, 1975. At that meeting Mr. L. M. Cornish, speaking for Kansas domestic insurance industry, told the committee that his group would accept a patient's compensation fund in which the first $100,000 of an award was paid by a private insurance carrier and the remainder from the fund. He told the committee that such a fund would be helpful in alleviating the problem and that his group would support it so long as it did not involve direct taxpayer support. He also noted that some states required insurance as a condition of licensure. (Minutes, September 23/24, 1975, pp. 2, 11.) Mr. Cornish distributed a comparison chart showing that the Kansas Medical Society, the Kansas Bar Association, and the Kansas insurance industry all supported a patient's compensation fund based upon an assessment on health care providers. (Minutes, September 23/24, 1975, Attachment L.)

39. The St. Paul Insurance Companies presented statistical data showing projections for a substantial loss for 1973 and 1974. (Minutes, September 23/24, 1975, Attachment C.)

40. The committee also discussed whether a patient's compensation fund should be mandatory to insure a large enough financial base for the fund to function or whether it should be optional. (Minutes, September 23/24, 1975, p. 6.)

41. At the next meeting of the interim committee, October 14, 1975, the chairman, Senator Wesley H. Sowers, recommended to the committee that it consider legislation establishing a patient's compensation fund financed by health care providers through a surcharge based on their premiums for $100,000 of private coverage. (Minutes, October 14, 1976, p. 7.)



42. The committee thereafter directed its staff to prepare a draft of a bill creating such a fund. (Minutes, October 14, 1975, p. 8.)

43. At its next meeting, October 28, 1975, the committee discussed the proposed bill that had been prepared by its staff in detail. (Minutes, October 28, 1975, pp. 6-8.)

44. At its last meeting, on November 13 and 14, 1975, the interim committee studied the details of the bill at length, made certain small amendments, and then approved it for introduction in the 1976 legislation. (Minutes, November 13/14, 1975.)

45. Thereafter, a report was prepared and filed with the Legislative Coordinating Counsel in January, 1976. The report contained 12 bills recommended by the committee for passage by the Legislature and the following conclusion:

> "The Committee found that the changes in the malpractice insurance market threaten health care in Kansas since some physicians believe they will not be able to continue in practice under such conditions. An adverse effect also arises from additional patient charges which result from passing on the increased cost of insurance through patient charges or daily room charges."

Report on Kansas Legislature Interim Studies to the 1976 Legislature Part II, p. 1155.

46. The bill in question, designated Senate Bill 646, was introduced in the Senate and referred to the Senate Committee on Public Health and Welfare. At its initial meeting, note was taken that various medical groups were recommending that the bill be amended to make partici-

pation mandatory. (Minutes, Senate Public Health and Welfare, January 20, 1976.)

47. At its meeting on January 26, 1976, the Senate Committee heard from David Fisher, who, on behalf of the Kansas Bar Association, stated that the bar association supported the health care stabilization fund to be created by Senate Bill No. 646. Mr. L. M. Cornish, on behalf of the Kansas domestic insurance industry, advised the committee that compliance with the act by purchasing insurance should be required of all health care providers and that the fund should be authorized to make installment payments. (Minutes, Senate Public Health and Welfare, January 26, 1976, pp. 1-2, Attachments A, D.)

48. Douglas Johnson, executive director of the Kansas Pharmaceutical Association, told the committee that pharmacists would like to be included within the definition of health care provider in all proposed bills. He recommended that insurance coverage be made compulsory for all health care providers and termed the patient's compensation fund concept "one of the major areas that will determine the success or failure of a solution to the problem." He also stated that "we feel that as professionals we owe it to other health care providers to contribute to that fund." (Minutes, Senate Public Health and Welfare, January 26, 1976, p. 2, Attachment E.)

49. Additional testimony was taken by the Senate committee on January 27, 1976.

50. Mr. Frank Gentry, executive director of the Kansas Hospital Association, distributed copies of material submitted to the interim committee on behalf of the Hospital Association. He also noted that mandatory participation would be recommended and that the Hospital Association would support that recommendation. He noted that "it



would be impractical to allow health care providers within any given category to cop out, thereby allowing the fund to be responsible for only the greater risk." He also indicated that the Hospital Association would support annual installment payments for large awards, a recommendation that would be forthcoming from the insurance department. (Minutes, Senate Public Health and Welfare, January 27, 1976, p. 1, Attachment A.)

51. Carl C. Schmitthenner, Jr., executive director of the Kansas State Dental Association, also appeared and noted that his group might have some objection to mandatory coverage. (Minutes, Senate Public Health and Welfare, January 27, 1976, p. 2.)

52. Judy Runnels, on behalf of the Kansas State Nurses Association, suggested to the committee that mandatory insurance for nurses could cause a number to simply stop working. (Minutes, Senate Public Health and Welfare, January 27, 1976, p. 2, Attachment D.)

53. Dr. Greg Snyder, on behalf of the Kansas Medical Society, told the committee that the society supported the proposed legislation. He also noted that one young doctor had elected to go to Oklahoma and another to Nebraska because of the more favorable malpractice insurance situation in those states. (Minutes, Senate Public Health and Welfare, January 27, 1976, p. 2.)

54. At its next meeting, on January 28, 1976, the committee heard from Commissioner Bell. He told the committee that the malpractice insurance market was in an extremely precarious condition and that if his office had not been able to assist health care providers who could not obtain insurance Kansas would have faced slowdowns, strikes, or other disruptions of medical services similar to those occurring in other states. (Minutes, Senate

Public Health and Welfare, January 28, 1976, Attachment A.)

55. Commissioner Bell also reported on a meeting held January 8, 1976, in his office with representatives of the Kansas Medical Society, Kansas Hospital Association, Kansas Bar Association, Kansas Trial Lawyers Association, Western Insurance Companies, Farmers Alliance Insurance Companies, Kansas State Nurses Association, Kansas State Dental Association, American Insurance Association, and Kansas Association of Property and Casualty Companies. He noted that all of those groups, with the exception of the nurses and dentists, had agreed that Senate Bill 646 should be amended to make the purchase of basic insurance coverage and participation in the health care stabilization fund mandatory for all health care providers as defined in the act.

56. Commissioner Bell then presented a series of amendments prepared by his office, one of which excluded nurses and dentists from coverage. He noted that mandatory participation in the fund was necessary to insure its success but that an exclusion for nurses and dentists, who had not been confronted with the serious malpractice problems, would not harm the solvency of the fund. (Minutes, Senate Public Health and Welfare, January 28, 1976, p. 2, Attachment A.)

57. Commissioner Bell also proposed that the act provide for payment of settlements or judgments in installments of $150,000 whenever the amount due from the fund was greater than that figure. He told the committee that such an amendment was necessary to insure that the fund would be adequate to meet the needs of all claimants by avoiding total dissipation by one or two extraordinarily large judgments or settlements. (Minutes, Senate Public Health and Welfare, January 28, 1976, Attachment A.)



58. On February 4, 1976, Commissioner Bell again appeared before the committee and told the members that in the 10 months immediately preceding the date of his appearance, his office had intervened in 87 cases involving health care providers in 45 different communities who were unable to obtain adequate professional liability insurance. He also addressed himself to whether compliance with the act should be mandatory, telling the committee that such a requirement would give the fund its best possible chance of success. He went on to say:

> "I realize that some of those expressing concern over the mandatory requirement are quite probably physicians who either don't purchase professional liability coverage at the present time or—more likely—have not yet encountered a problem with respect to its cost or availability. As I said earlier, I can understand and appreciate their feeling but in all sincerity, I believe their good fortune has blinded them to the realities of the situation. First—while they may have not yet been confronted with the problem of a cancellation or non-renewal notice or a call from their insurance agent informing them that their application for coverage has been declined—the chances are that they will experience this kind of situation if this session of the legislature fails to take meaningful and responsive action. Secondly, I believe they are ignoring the fact that the problem is not isolated to one particular medical specialty but even if it was I have to wonder if they have considered what would happen if suddenly there is no surgeon in the community to which they can refer a patient for a necessary operation because the surgeon was unable to obtain

or afford what he or she believed was adequate professional liability protection—or, if the surgeon is still there what happens if there is no anesthesiologist available. To put it another way—I know we have all considered the specialization of medical technology as one of the factors contributing to the medical malpractice problem, but I believe that some health care providers have apparently failed to recognize the fact that they too must now depend on specialists to an ever increasing extent. In other words, we have reached the point where a surgeon's problems are also a problem for the general practitioner—the anesthesiologists' problems are also a problem for the surgeon—and so on. As a result, the suggested amendment to Senate Bill No. 646 which incorporates the mandatory element is simply a continuation of this mechanism. All it does in a sense is suggest that just as the very specialties support and complement each other in their rendering of medical care they must also support and complement each other with respect to professional liability protection."

(Minutes, Senate Public Health and Welfare, February 4, 1976, Attachment A.)

59. Bell also told the committee, once again, that dentists and nurses could be excluded from coverage because they had not encountered problems and that the committee also might wish to consider adding pharmacists and optometrists. He warned, however, that removal of medical care facilities or persons licensed from the Healing Arts Act would in essence destroy the act. (Minutes, Senate Public Health and Welfare, February 4, 1976, Attachment A.)



60. On February 13, 1976, the bill was reported by the committee favorably for passage, with various amendments including mandatory coverage, exclusion of nurses and dentists, and provision for installment payments. Note was made in the minutes that the installment provision was to protect the fund. (Minutes, Senate Public Health and Welfare, February 13, 1976.)

61. The bill then went to the House and was assigned to the House Committee on Insurance. On March 2, 1976, the committee heard a detailed explanation of the bill and the rationale underlying its provisions. (Minutes, House Committee on Insurance, March 2, 1976.) The committee had previously considered a variety of other malpractice bills and had heard detailed explanations of the problem. (Minutes, House Committee on Insurance, January 28, 29, 30; February 4, 5, 6, and 11, 1976.) Also on March 2, a representative of the Kansas Association of Nurse Anesthetists requested inclusion for his group in Senate Bill 646. (Minutes, House Committee on Insurance, March 2, 1976, p. 2.)

62. The committee thereafter heard testimony from a number of groups, all of whom except the nurses and dentists supported the bill and its mandatory coverage provision. (Minutes, House Committee on Insurance, March 3, 4, and 5, 1976.)

63. Thereafter, the committee considered technical amendments to the bill, and on March 12 reported it favorably for passage. (Minutes, House Committee on Insurance, March 9, 10, 11, and 12, 1976.)